State of the State presentations:

Chris Miller – DARS Funding participation rules

This comes from the contract with providers. Also KSAs for CM. – These came from all job descriptions for CMs re: DARS from across the state. See slides with KSAs for DARS/CM

- Per Chris, 1,800 – 2,000 across the continuum for caseloads. In a few weeks she should have better detail.

Brian asked for any comments/concerns related to the DARS KSAs structure:

- Barb Seymour → Agree all information provided similar to the state's reviewed by DMAS.

- Alexis Aplasca → How is CM structured in other states. Is this consistent with other states:
    - TCM may be open to all private and/or public providers
    - TCM often targets certain designated entities to provide this
    - Foster Care, SA case management are also opened to private providers. This is consistent with other states. Some states will conduct the TCM themselves as a state. Texas uses this state TCM provider.
        - Alexis – is there a 'preferred' model? This should be considered.

- Sara Benoit – is there a maximum caseload? This has been discussed and trying to understand what that should look like. This is a WIP.

- Will VA provide TCM as FFS or via CMO? For VA it will be an MCO services.

- Christy Evanko – re; CM – sounds more like a solo provider description – this is state-funded under DARS; not Medicaid.

    - Christy wants to know how you incorporate other providers into this role – how would we bring in a team?
        - Per Chris – it matches regardless of solo or other provider. Could be both. CM captures, referral, linkage and/or access to services, and developing the plan – coordinating the team to capture the detail.
    - Per Daniela Pretzer – "We are connecting clients with other service providers and team with them."
    - Barb Seymour – based on a team approach.
    - Jason Young – the 'HUB' of the wheel connecting to other services. Doctors may not directly talk to the patient, but coordinates the effort. This would be the CM fx.
    - Ann – how do the elements outlined in the CM fx begin to dovetail with the waiver and how will they align?
        - Per Brian – it will need to 'dovetail' and compliment the other services. More detail will come.
        - How does the delivery methods work? More to come.

- Daniela Pretzer - We are connecting clients with other service providers and team with them. Will the individual have choice? If they fund CM and DARS does this, one must do one thing, then the other organization must do a different service.

    - Brian - It would be among the Medicaid funded services. The state will need to consider how to use state vs. federally funded dollars. General fund dollars offers more latitude.
    - The CM will not be able to be the provider in tandem with the CM. They cannot deliver both.
    - Angie - Federal Home and Community Based Services (HCBS) conflict of interest rules prohibit TCM providers from being waiver service providers

Jason Young/ED – **Community Brain Injury Services** – Summary of current service delivery for case management – provided a spreadsheet of services. [see spreadsheet] Jodi Judge/Brain Injury Service SW, and Lisa McCarthy/Brain Injury Services.

- Definitions for CM
- Responsibilities for CM

Lisa

Nuances

- Strength-based and person-centered.
- Walk the path with them
- Info and Referral
- Assisting with access to services
    - Education that CM provides. Provide soft hand-off with services.
    - Help build support system around the client.
- Needs Assessments conducted
    - Pull together and develop the plan

Jodi

CM Service Definition/Activities

- Services are tailored to the specific needs of each individual and how their deficits impact them individually – and determining how intense the interventions and service supports should be.
- **Time and labor-intensive** due to the tailored approach.
    - Takes about 90 days initially to develop plan.
    - Lengthy process d/t the need to understand full scope of functional levels and needs from injury.
    - Educate along the way re: the new normal, services available, etc. Ambiguous loss is a real issue.
    - CM is the 'hub' or a 'wheel' – the hub doesn't go anywhere where the wheel doesn't go. May be assessing needs, may need psychiatrist, go back to work, etc. Who are key players?
    - Person-Centered, Goal-Driven and Open-ended in service approach.

- Services must be flexible to accommodate emerging needs of the individual.

Jason Young

- High Points
    - Accreditation – accredited under CARF employment & community services standards. CM is known as Services Coordination.
    - Overview on CARF
        - Best practice standards are updated annually.
        - Peer review process with focus on quality improvement across all areas of organization. Includes service delivery, caregivers, all business operations too. Health safety, outcomes, strategic planning, finances, etc.
            - Unlike licensure approach, this is a quality improvement peer review; not just to 'got ya'. Looking at the uniqueness of services to build upon.
    - Recommendation – TCM should be CARF accreditation under employment and community services standards. This is the goal standard.
    - Outcomes Scorecard
        - Jason provided brief summary on scorecard.
    - Outcomes – being CARF accredited – requires this in 4 areas:
        - Service access
        - Efficiency
        - Effectiveness
        - Stakeholder satisfaction

$$ associated with services

1 FTE for CM = $95,000 and NOVA = $110,000 as of 2020. → this includes A&OH and is an average.

Staff training and hiring requirements – **ACBIS certification** and most of the CMs are certified. Requires a min of 500 DIRECT SERVICE HOURS working with brain injury before sitting for exam. 80% pass rate to pass.

RECOMMEND – using this as hiring requirement in conjunction with at least a BS in Human Services, Master's preferred. CTE 10 per year → Could use the 10 hours specific to Brain injury CTE each year. Could also look at professional certificate (Brain Injury Association of VA).

Optimal caseload = 25 per FTE.

Some have follow-along step-down service which is not as intensive as the above. Meant to transition them off CM.

- Follow-along
    - When does someone get designated and how is it determined?
        - Specific policies
            - When goals are less intensive. Goal achievement objectives have been met toward ultimate goal. They become 'maintenance' goals. This is a good place to develop a follow-along strategy. These are done quarterly.

        - What happens in crisis occurs?
            - Individuals may move in and out of intensity of services based on need. Can place them back into active status.
            - Caseload sizes can remain at about 25.
- Brian asked that all providers get their case management figures together. Case Manager to individual will be helpful.
- Chris Miller will put together aggregated numbers across the state for next meeting.

Barb Seymour – F2F – asked providers to share about monitoring timeframes, etc.

F2F vs. telehealth or check-in telephonically – is there a protocol?

Jason – yes. Under services planning within 90 days and then 30 day contact and 45 day F2F meeting with them. These are minimums. – this may differ between providers. There isn't a universal set of requirements specific to the frequency and F2F – but they are all guided by CARF.

QUESTIONS TO CONSIDER:

1. WILL TCM service all ages? Significant different between pediatric and adult CM?
2. Severe TBI – remains the question on how that will functionally be defined to the service population? **This is a functional definition they are looking for**. Not medically related. Consider GLASCO???
3. Based on above, how many individuals will be eligible and need the service?

Pediatric v. Adult – the state could put a limit on a waiver but not a state plan service such as TCM. May need to consider alternative services contingent on the age.

- Pediatric
    - Peds-specific vs. Peds/Adults combined
    - Peds-only – college age
    - Peds clients are held on to much longer. They are the one stable service provider as they graduate through each grade and experience turnover of other providers. Also serving the whole family.
    - Different resources and benefits to consider
    - Advocacy and school-system is a big consideration
        - Some school systems WONDERFUL
        - Others not so much
- Hybrid = combined Peds/Adults combined
    - Helps to transition peds to adult services using same CM.
    - At the 18th birthday there are considerations that must be in place by then such as 'guardianship', etc.

Marina Hench - Is there some overlap between case management and IADLs? How do you coordinate that with other provider types?

Jamie Peed - I am the only Case Manager for over 38,000 in South Hampton Roads

Jennifer Faison, VACSB - It might make sense to contemplate the language going forward. If you are on Zoom, you are

from Jennifer Faison, VACSB to everyone - face to face, but you are not in person

Shirley Richardson - I wanted to know the difference as well. Is there a way to define severity?

Chris Miller - Do individuals have the ability to choose a waiver if they are eligible for more than one? (for example brain injury waiver and ID/DD waiver).

Ann Bevan - DD and ID are also holistic however the waiver plan is obviously focused on waiver or Medicaid billable services. However, the waiver plan is obviously focused on waiver or Medicaid billable services.

Project Updates provided by Brian:

- TA plan – new edition – has begun
- Data Planning – not much progress. More in a week or two on sharing options
- Rate Development vendor – RFP closes out in a few weeks
- Legislative Report – completed DRAFT and in the DMAS review process. Thank you all for your comments.

This and next meeting – drill-down on the CM function to wrap up this part of the project by end of October. Details specific to this within the next few weeks. Allow rate vendor to rate with these details in mind.

More detail on program-specific TCM elements and requirements to come. May breakout into smaller groups for this.

- Q. Barb Seymour
    - Average qualifications currently?
    - Master's preferred in Social Services field.
    - Majority are SW or Rehab counseling background. Have had some RNs, OTs, etc. Sometimes challenge is adjusting to PCP model.
- Q. Barb Seymour
    - Waitlist questions. Are there service areas with waitlists?
    - This is region by region. In NOVA are now adjusting and increased staffing, goal is no more than a 6 month wait. Based on 'NEED' and then by Date of contact.
    - In Virginia Beach they have 1 CM. Drives
- Q: Chris Miller – will provide the waitlist numbers too. TCM additions will increase capacity to provider services statewide.
    - There are gaps across the states with limited to no case management supports for brain injury.
- Q: Brain – with the training, it sounds failry intensive.
    - Yes, new training includes section on neuro-anatomy and neuro-physiology. Cost is also about $300 per or individual is $350. Also must reapply each year. Some providers give an 18 month window in conjunction with the 500 experience hour component.

Brian to ask the TA staff what other states are requiring for training and ed.

State TCM Options Overview & Homework:

- Q: Jennifer Faison - As you all are going through the models from other states, it might be helpful to also ensure that the resources to support those practices and outcomes are highlighted as well. See answer below.

- Brian will forward a homework assignment with CM models from other states (3-5 states to consider) – Brian will send out within the next few days.

    - Service planning
    - Activity requirements
    - Within a few weeks begin to assimilate the states and best-practice approaches
    - Service definitions
    - Population definitions

- Will discuss at next meeting the model wished to be used. Identify strengths from the various models to develop a Virginia model. The current model will likely align well with some of the other offerings from the other states.

Postings will begin on the website within the next few weeks for legislators and for the public at-large.

Appropriation – is the $4,000,000 – who will it serve? Does Medicaid know?

- House Bill 680 – look at the budget fiscal impact statement – will show what DMAS estimated. **Sara Benoit** – provided quick overview on how rates were determined on the above.